



SuperMed Plus
BORMA - City of Bowling Green
Effective 01/01/12
Non-Grandfathered Plan



Benefits	Preferred Provider	Nonpreferred Provider
Benefit Period	January 1 st through December 31 st	
Dependent Age	26/in accordance with Federal Law	
Older Age Child	28/in accordance with Ohio law Removal upon End of Month	
Pre-Existing Condition Waiting Period	Does not Apply	
Annual Benefit Maximum	\$2,000,000	
Benefit Period Deductible – Single/Family ¹	\$200 / \$400	\$400 / \$800
Coinsurance	80%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$400 / \$1200	\$1,200 / \$3,600
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$20 copay, then 100%	70% after deductible
Urgent Care Office Visit	\$35 Copay then 100%	70% after deductible
Medically Necessary Immunizations (Rabies, Tetanus Toxoid, Meningococcal Polysaccharide/conjugate)	*100%	*100%
Preventive Services		
Preventive Services, in accordance with state and federal law³	*100%	70% after deductible
Routine Physical Exam including laboratory, x-rays, and medical tests (Ages 21 and over)	*100%	*100%
Routine Immunizations	*100%	*100%
Well Child Care Services including Exam and laboratory and immunizations (To age 21)	*100%	*100%
Routine Mammogram (One per benefit period)	*100%	*100%
Routine Pap Test (One per benefit period)	*100%	*100%
Routine Endoscopic Services	*100%	*100%
Outpatient Services		
Surgical Services	80% after deductible	70% after deductible
Diagnostic Services	80% after deductible	70% after deductible
Diagnostic Endoscopic Services	*100%	*100%
Physical Therapy - Facility and Professional	80% after deductible	70% after deductible
Occupational Therapy – Facility and Professional	80% after deductible	70% after deductible
Chiropractic Therapy	80% after deductible	70% after deductible
Speech Therapy – Facility and Professional	80% after deductible	70% after deductible
Cardiac Rehabilitation – Facility and Professional	80% after deductible	70% after deductible
Emergency use of an Emergency Room ⁴	\$50 Copay, waived if admitted, then *100%	

* Not Subject to Deductible

Benefits	Preferred Provider	Nonpreferred Provider
Non-Emergency use of an Emergency Room ⁴	\$50 Copay, waived if admitted, then *100%	70% after deductible
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	70% after deductible
Newborn Care	*100%	70% after deductible
Maternity	80% after deductible	70% after deductible
Skilled Nursing Facility (120 days per benefit period)	80% after deductible	70% after deductible
Organ Transplants	80% after deductible	70% after deductible
Additional Services		
Allergy Testing and Treatments	80% after deductible	70% after deductible
Ambulance	80% after deductible	70% after deductible
Education and Training	80% after deductible	70% after deductible
Durable Medical Equipment -Jobst stockings limited to two pair per 12 months -Mastectomy bras limited to two per 12 months -Wigs- one per lifetime	80% after deductible	70% after deductible
Home Healthcare (60 visits per benefit period)	80% after deductible	70% after deductible
Hospice (180 days per lifetime)	80% after deductible	70% after deductible
Private Duty Nursing	80% after deductible	70% after deductible
TMJ (\$3,000 per lifetime)	80% after deductible	70% after deductible
All Other Covered Services	80% after deductible	70% after deductible
Mental Health and Substance Abuse – Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	Benefits paid based on corresponding medical benefits	
Outpatient Mental Health and Substance Abuse Services		

Note: Services requiring a copayment are not subject to the single/family deductible.

Deductible and coinsurance expenses incurred for services by a nonpreferred provider will also apply to the preferred provider deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for services by a preferred provider will also apply to the nonpreferred deductible and coinsurance out-of-pocket limits.

Benefits will be determined based on Mutual Health Services' medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Mutual Health Services' may agree, orally or in writing, to change the benefits listed here. The contract or benefit book will contain the complete listing of covered services.

In certain instances, Mutual Health Services' payment may not equal the percentage listed above. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or the negotiated rate with the provider.

¹Maximum family deductible. Member deductible is the same as single deductible

²The office visit copay applies to the cost of the office visit only.

³Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

⁴The copay applies to room charges only.